CONNECTICUT WOMEN'S HEALTH CAMPAIGN

c/o Permanent Commission on the Status of Women
18-20 Trinity Street Hartford, CT 06106
Phone: (860) 240-8300 E-mail: pcsw@po.state.ct.us
Fax: (860) 240-8314 Website: www.cga.state.ct.us/pcsw

The Connecticut Women's Health Campaign

African American Affairs Commission
CT Association for Human Services
CT Association of School Based Health Care (CASBHC)
CT Breast Cancer Coalition, Inc.
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Latino and Puerto Rican Affairs Commission
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NARAL Pro-Choice ConnecticutNational Association of Social Workers, CT Chapter
National Council of Jewish Women
National Ovarian Cancer Coalition CTOlder Women's League of NWCT
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UCONN Women's Center-Women's Health
Urban League of Greater Hartford, Inc.
Valley Women's Health Access Program, Griffin Hospital
Yale University School of Medicine

Briefing Papers on Women's Health FEBRUARY 2004

In Memory of Nancy Pilver

On May 10, 2003 Nancy Pilver passed away after a long struggle with breast cancer, and Connecticut lost one of its most passionate and effective advocates for women's health. Members of the Connecticut Women's Health Campaign also lost a dear friend and colleague.

Nancy had been a member of the CWHC from nearly the beginning and had led the fights to win state funding for breast and cervical cancer early detection programs, coverage of minimum hospital stays for certain mastectomies and a voluntary contribution box on the state income tax form for breast cancer research and education.

We are grateful for her life and her work, and we mourn her loss.

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Connecticut Women's Health: A Blueprint For The Future Summary Bill

PREVENTION & GENDER COMPETENT SERVICES

Environmental Causes And Mapping Of Breast Cancer

▪ Provide funding to the state Department of Public Health for the purpose of mapping the incidence of breast cancer to determine whether there are any "clusters" in CT that might indicate environmental causes of the disease.

Osteoporosis Early Detection And Treatment Referral Program

▪ Require the state Department of Public Health to establish an osteoporosis prevention, early detection and treatment referral program to promote prevention, screening detection and treatment of osteoporosis among unserved or underserved populations, to educate the public regarding osteoporosis and the benefits of prevention and early detection and to provide counseling and referral services for treatment.

Nutritional Counseling And Therapy

▪ Require insurers to provide coverage for medically necessary Medical Nutrition Therapy authorized by a physician for conditions including, but not limited to: hypertension, hypercholesterolemia, hypertriglyceridemia, obesity, morbid obesity, eating disorders, inflammatory bowel disease, gastro-esophageal reflux disease, chronic renal insufficiency, cancer, HIV, unexplained weight loss, malnutrition, malabsorption, prenatal nutrition care, enteral nutrition support and parenteral nutrition support.

School Nutrition to Prevent Osteoporosis, Obesity and Other Diseases

▪ Require all schools to adhere to state regulations regarding the sale of "extra foods," defined as tea, coffee, soft drinks and candy, in vending machines.

- Require the state Department of Education to create stronger enforcement mechanisms for existing regulations that require schools to shut off vending machines, containing "extra foods,"

Gender Competent Behavioral Health Treatment And Services

- Require all state funded behavioral health programs to provide gender competent treatment and services to meet the complex needs of women with behavioral health problems.

Improving The Response System For Sexual Assault Victims

- Provide funding for five regional Sexual Assault Response Team Coordinators to establish Sexual Assault Response Teams (SART) throughout the state.

ACCESS TO HEALTH CARE

Health Insurance Expansion

- Require the state Department of Social Services to apply for a federal waiver to provide insurance coverage for (A) all parents up to 300% of the federal poverty level; (B) pregnant women up to 300% of the federal poverty for up to two years after a pregnancy; and (C) for family planning, including STD diagnosis and treatment, for adults up to 300% of the federal poverty level.

- Require the state Comptroller to allow small business employers to obtain insurance coverage through the Municipal Employees Health Insurance Plan (MEHIP). (PA 03-3 and PA03-149 passed)

Gynecological Services For Women With Disabilities

- Pursuant to passage of PA 03-40, Gynecological Services for Women With Disabilities - Support proposals to implement the recommendations of the Advisory Committee for Access to Gynecological Services for Women With Disabilities, such as:

- Establishing a medical advisory group to reinforce and disseminate current best practices and to develop standards for the provision of care specific to the needs of women with cognitive, psychiatric and / or physical disabilities;

- Charging a regulatory body to monitor standards in all settings for the provision of care developed by the medical advisory group that are specific to women with cognitive / psychiatric and / or physical disabilities; Working with state Medicare, Medicaid and managed care organizations to increase the reimbursement rates for extended visits for clients with disabilities; and

- Increasing public and professional awareness on disability issues.

Prescription Drug Coverage

- Ensure that consumers have access to reasonably priced prescription drugs by establishing a state purchasing system that creates discounted prices for prescription drugs, and a review board to monitor prescription drug prices.

Patients' Right to Know

- Protect all patients' right to know about medical options and to make informed decisions regarding their health and medical care by ensuring that no hospital, health care clinic, health care provider, health maintenance organization, insurer, or other entity shall, by contract, by law or other means prohibit a physician or other health professional from discussing or recommending any medical treatment or medication that is medically accepted and a reasonable option for a patient's condition or ongoing treatment, regardless of whether the treatment or medication is available at the location at which the patient is treated.

Midwifery Care

- Protect consumer access to professional, out-of-hospital maternity care services and increase the range of quality maternity care choices available to consumers.

SUPPORTING COMMUNITY HEALTH

Restore Health Services

- Restore Medicaid, State Administered Medical Assistance (SAGA), and town General Assistance (GA) medical coverage to include eye care, optical hardware, optometry care, home health care, and services by psychologists, naturopaths, chiropractors, physical, occupational and speech therapists and podiatrists.

- Restore SAGA non-emergency medical transportation.

Expand Community Health Services For The Uninsured

- Expand services at community health centers and school based health clinics to adequately serve the uninsured.

Smoking Prevention And Cessation

- Provide funding to the state Department of Social Services for the purpose of implementing its Medicaid state plan to provide smoking cessation services.

Community Support Services For Elders And People With Disabilities

- Comply with the U. S. Supreme Court ruling in Olmstead v. L. C., 119 S. Ct. 2176 (1999), by providing community support services for elders and people with disabilities and wish to live in the community.

EDUCATION & AWARENESS

Biennial Report On The Health Status Of Women

- Provide funding for a biennial report to provide information regarding breast and ovarian cancer, domestic violence, sexual assault, and the link between smoking, weight loss and obesity, HIV / AIDS, depression, adolescent health, emergency contraception, and access to services by women with disabilities.

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2004 Legislative Priorities

Access to Health Care

Medicaid and State Assisted General Assistance (SAGA) - Seek restoration of funding for cuts that were implemented in the 2003 legislative sessions.

Health Insurance Coverage for Chemotherapy Related Services - Require insurance coverage of wigs for patients who have lost hair as a result of chemotherapy.

Gynecological Services for Women With Disabilities - Support proposals to implement the recommendations of the Advisory Committee for Access to Gynecological Services for Women With Disabilities, such as:

- Establishing a medical advisory group to reinforce and disseminate current best practices and to develop standards for the provision of care specific to the needs of women with cognitive, psychiatric and / or physical disabilities;

- Charging a regulatory body to monitor standards in all settings for the provision of care developed by the medical advisory group that are specific to women with cognitive / psychiatric and / or physical disabilities; Working with state Medicare, Medicaid and managed care organizations to increase the reimbursement rates for extended visits for clients with disabilities; and

- Increasing public and professional awareness on disability issues.

Racial Disparities in Access to Health Care - Support proposals to prevent budget cuts to HIV / AIDS programs, particularly for prevention and treatment programs for women of color who have or are at risk for HIV infection.

Prescription Drugs - Support proposals to provide affordable prescription drugs.

Prevention & Gender Competent Services

Nutrition and Eating Disorders - Support proposals that address the need for education and services regarding nutrition and eating disorders, such as:

- Regulating vending machines at schools, and
- Requiring coverage for medical nutrition therapy

Racial Disparities in Quality of Health Care - Support proposals to provide gender and culturally competent services.

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Connecticut Women's Health Campaign Ten Years of Progress

The Connecticut Women's Health Campaign's legislative agenda addresses women's health issues across the life span by promoting public policies to increase preventive, gender competent services, increase access to health care, and support community health initiatives.

The Connecticut Women's Health Campaign (CWHC) is a group of organizations committed to protecting and improving the health and well-being of women and girls in Connecticut. This group of diverse organizations plays an important role in highlighting issues affecting women's health. All of the accomplishments listed below were achieved in partnership with other organizations and legislative leaders.

1995 Women now have direct access to OB/GYNs and other reproductive health care providers without approval by Primary Care Physicians for reproductive health care. An OB/GYN can also be a woman's Primary Care Physician.
C.G.S. Secs. 38a-503b and 38a-530b. Carriers to permit direct access to obstetrician-gynecologist.

1995 Health insurers are prohibited from discriminating against anyone who has been a victim of domestic violence.
C.G.S Sec. 38a-816 (18). Unfair practice defined.

1996 State budget includes $1.8 million for free mammograms and Pap tests to uninsured and underinsured women between the ages of 40 and 64 whose income is at or below 200% of poverty. In addition, the Department of Public Health will offer public and professional education, establish a tracking system, fund diagnostic follow up for those women who require it, and refer women to appropriate treatment.

1996 Insurers are required to cover a minimum of a 48-hour hospital stay for normal childbirth and 96 hours for caesarean section.
C.G.S. Secs. 38a-503c and 38a-530c. Mandatory coverage for maternity care.

1996 Insurers are prohibited from considering prior history of breast cancer as a "pre-existing condition" if a person has been cancer free for five years or more.
C.G.S. Secs. 38a-503a and 38a-530a. Mandatory coverage for breast cancer survivors.

1997 Insurers are required to cover a minimum hospital stay of 48 hours for partial mastectomy and other breast cancer surgery.
C.G.S. Secs. 38a-503d and 38a-530d. Mandatory coverage for mastectomy care. Termination of provider contract prohibited.

1997 Insurers are required to cover breast reconstruction surgery after a mastectomy.
C.G.S. Sec. 38a-504 and 38a-542. Mandatory coverage for treatment of tumors and leukemia. Mandatory coverage for reconstructive surgery, prosthesis and chemotherapy. Mandatory coverage for breast reconstruction after mastectomy.

1997 A mother cannot be prohibited from breastfeeding her child in public.
C.G.S. Sec. 46a-64. Discriminatory public accommodations practices prohibited.
C.G.S. Sec. 53-34b. Deprivation of the right to breastfeed one's child.

1997 A check-off box on the state income tax form allows individuals to designate voluntary contributions to breast cancer research and education.
C.G.S. Sec. 19a-32b. Breast cancer research and education account. Regulations.

1998 Use of genetic information in employment decisions is a prohibited discriminatory practice.
C.G.S. Sec. 46a-60(a)(11). Discriminatory employment practices prohibited.

1999 Whenever a health insurer covers prescriptions, it must also cover all FDA approved prescription contraceptive methods.
C.G.S. Secs. 38a-503e and 38a-530e. Mandatory coverage for prescription contraceptives.

1999 The Commissioner of the Department of Social Services is authorized to amend the Medicaid State Plan to provide coverage for smoking cessation treatment and aids ordered by a physician.
C.G.S. Sec 17b-278a. Coverage for treatment for smoking cessation.

1999 An Osteoporosis Education and Awareness Advisory Council is created to coordinate efforts for preventive activities, including public education.
Special Act 99-9 An Act Creating an Osteoporosis Education and Awareness Advisory Council

2000 HUSKY A health coverage is expanded to include parents with household incomes up to 185% of poverty. (This expansion has since been repealed.)
C.G.S. Sec. 17b-261. Eligibility. Assets. Children.

2000 Working people with disabilities can continue to receive health care coverage through Medicaid with incomes up to 200% of the federal poverty level.
C.G.S. Sec. 17b-597. Working persons with disabilities program. Eligibility. Regulations.

2000 An Advisory Commission on Multicultural Health is created to oversee the Office of Multicultural Health within the Department of Public Health.
C.G.S. Sec. 19a-4k. Advisory Commission on Multicultural Health.

2001 Medicaid coverage is provided for all medical treatment for women diagnosed with cancer through the state's Breast and Cervical Cancer Early Detection Program.
C.G.S. Sec. 17b-278b. Medical assistance for breast and cervical cancer.

2001 Insurers are required to provide coverage for routine patient care costs associated with cancer clinical trials; a baseline mammogram for women ages 35 – 39, and a yearly mammogram for women over age 40. Pap smear tests are also included in the definition of OB/GYN services.
C.G.S. Sec. 17b-278c. Amendment to state Medicaid plan to provide mammogram examinations to certain women.

2001 Employers are required to make reasonable efforts to provide a private space (other than a toilet stall) for an employee to express her milk. Employers are prohibited from discriminating against employees who breastfeed / express at work.
C.G.S. Sec. 31-40w. Breastfeeding in the workplace.

2002 The Medicaid state plan must include coverage for treatment for smoking cessation.
C.G.S. Sec 17b-278a. Coverage for treatment for smoking cessation.

2003 The Department of Public Health is directed to develop recommendations to improve access to gynecological services for women with disabilities.
PA 03-40

2003 Eligibility for participation in the Municipal Employees Health Insurance Plan (MEHIP) is expanded to include small businesses, community action agencies, and other groups.
PA 03-3 and PA 03-149

The Connecticut Women's Health Campaign has addressed other vital women's health issues in support of organizations or coalitions that had specific expertise and took the lead in these efforts. Some of these issues include:

- Access to reproductive health care, including efforts to monitor hospital mergers and other transactions that might reduce access to comprehensive reproductive health care services
- Access to domestic violence services for women with disabilities
- Access to services and protections for all victims of sexual assault and domestic violence
- Access to home care for the elderly and people with disabilities
- Expansion of state Family and Medical Leave Act benefits to allow working parents to protect their own health and the health of family members

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MEDICAID AND SAGA
Critical Women's Health Programs

The Connecticut Women's Health Campaign supports universal coverage that is affordable and accessible for all people regardless of income, age employment status, immigration status or location of residence. For this reason the CWHC supports full funding for health care safety net programs and the repeal of co-pays and premiums that will cause low-income families to lose coverage, delay doctor's visits and forgo medications.

The Problem

Health care coverage through Medicaid and SAGA is critical to low-income women in Connecticut, but access to this coverage is being threatened by the imposition of new co-pays and premiums for enrollees.

Medicaid provides access to vital health services at all stages of life, including acute and preventive care, pregnancy-related services, nursing home and long-term care. Women comprise the vast majority of adults enrolled in Medicaid, and over half of the adults enrolled in SAGA. As of November 2003, approximately 147,000 women were obtaining access to health services through Medicaid: 124,405 female parents and caregivers (HUSKY A), 14,945 elderly women, 7,385 non-elderly women with disabilities, and 130 women with breast or cervical cancer.[1]

Women have longer life spans and are more likely to require long-term care. Low-income elderly women rely on Medicaid for prescription drug coverage, nursing home care and home-based healthcare services. In 2003, 43,383, or 67% of nursing home residents, were female.[2] On any given day, two-thirds of the nursing home residents in Connecticut are on Medicaid.[3] Medicaid closes gaps in Medicare coverage by paying premiums and deductibles for low-income enrollees. Medicaid also provides prescription drug coverage, which is essential because, according to the Food and Drug Administration (FDA), older women take an average of seven prescription medications.

Low-income women in Connecticut rely on Medicaid coverage for access to all family planning services including contraception and abortion, gynecological services, testing and treatment of STD's. Medicaid pays for 25% of births in Connecticut, [4] and covers half of all births in many Connecticut cities.[5] In 2001, Medicaid paid for almost 12,000 births in Connecticut.[6] Medicaid covers pregnancy-related care and postpartum care for 60 days for low-income women up to 185% of poverty and for their newborn children up to one year of age.

Medicaid also pays for treatment for serious diseases such as breast and cervical cancer and HIV/AIDS care. In 2001, Connecticut took the new federal option to use Medicaid funds to provide medical treatment to low-income women who would not otherwise be eligible for Medicaid and who were diagnosed with breast or cervical cancer through the state's Breast and Cervical Early Detection program. Currently, 130 women are receiving treatment for cancer under this program. Medicaid is also the largest public funding source for HIV/AIDS care, which is vital when considering that the rate of HIV infection among women in this state is twice the national average.

In addition to providing essential health services, Medicaid also creates jobs for women in the health care industry. Connecticut receives over a billion dollars in federal funds to help pay for health care services and supplies. There are over 36,000 jobs in Connecticut financed through Medicaid, resulting in over $1.5 million in wages. Women and men work as nurses, lab technicians, pharmacists, suppliers, physicians, hospital staff, nursing home staff, and administrators in this industry. Cutting expenditures in this sector is bad medicine for Connecticut's economy.

What Can Be Done?

Connecticut's health care safety net programs, including SAGA, HUSKY A, HUSKY B and other Medicaid programs, must be preserved and continue to be affordable and accessible to those who need them. Co-pays and premiums should be eliminated and benefits should not be reduced. Eligibility for HUSKY A should be restored for parents with household incomes up to 185% of the federal poverty level.

For additional information, please contact:

CT Chapter/American Academy of Pediatrics
c/o Judith Blei, Government Relations
104 Hungerford Street
Hartford, CT 06106
860-525-9738
judy@jblei.com
Susan Merrow
smerrow@mindspring.com

Covering Connecticut's Kids and Families
Lisa Sementilli
60 Gillett Street, Suite 204
Hartford CT 06105
(860) 548-1661
Fax (860) 548-1783
E-mail: chc@hfpg.orghttp://
www.childrenshealthcouncil.org

Health Care for All
Gretchen Vivier, Coordinator
139 Vanderbilt Ave.
West Hartford, CT 06110
860-947-2211
gvivier@ccag.net

Legal Assistance Resource Center of Connecticut (LARCC)
Jane McNichol
85 Jefferson Street
Hartford, CT 06106
860-278-5688
jmcnichol@larcc.org

Endnotes
[1] DSS Data.
[2] CT Commission on Aging.
[3] *Older Women: A Diverse and Growing Population*
; Administration on Aging, Washington, DC
[4] Children
's Health Council.
[5] Ibid.
[vi] Ibid.

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Prescription Drug Coverage

The Connecticut Women's Health Campaign (CWHC) supports measures to ensure that consumers have access to reasonably priced prescription drugs. This initiative is consistent with the CWHC principle of providing a comprehensive benefits package which covers a full range of services.

The Problem

More than 1,000,000 state residents are without prescription drug coverage,[1] while state expenditures on pharmaceuticals increased 18% during FY02 to a total of $719 million in FY03.[2] Many state programs are being cut due to lack of adequate revenue.

Women are generally more likely than men to use prescription drugs. Some 40 percent of men and 66 percent of women age 18 to 34 use prescription drugs. Use patterns converge as people get older, however. Similar proportions of men and women age 65 and older are prescription drug users.[3] One must remember, though, that 58% of the over 65 population are females. [4]

Older women are significantly affected by the rise in prescription drug costs. According to the U.S. Food and Drug Administration, older women take an average of seven different medications at any given time. The majority of older women rely on Medicare coverage that currently does not cover prescription medications. This lack of prescription coverage translates into a hefty individual bill. According to the Kaiser Foundation the average price per prescription in Connecticut was $58.09 in 2002.[5] For older women taking an average of seven different medications, this translates into $407 a month for out-of-pocket drug expenses.

What Can Be Done?

(A) Establish a state purchasing system, which creates discounted prices for prescription drugs, (B) Require disclosure of marketing costs by pharmaceutical companies, (C) Investigate the feasibility of allowing ConnPACE participants and state employees to order their prescription drugs through certified Canadian pharmacies, and (D) Establish a review board that includes consumers to monitor prescription drug prices.

A review board would support all of the initiatives listed above by looking at options for lowering drug prices, targeting costly drugs, monitoring preferred drug list plans, monitoring prior authorization, providing representatives to

regional organizations with other states making plans for bulk-purchasing, reviewing drug education programs (often called "counter-detailing" programs) for consumers and doctors, and analyzing and reporting drug manufacturer marketing costs.

These initiatives could be mandated through legislation or implemented administratively. There might be some small administrative costs, but those would be more than offset by what the state could save on prescription drugs for Medicaid and state employee coverage.

Number of Women Affected

75% of all women use prescription drugs.[6] Those that do not have prescription drug coverage are paying the highest costs for their prescriptions. Those that do have coverage are seeing their coverage getting more expensive and their share of the cost getting higher. The high cost of prescription drugs affects even those women who are not using them by raising the cost and decreasing the amount of other health care coverage.

How Savings Can Be Achieved

A statewide or region-wide purchasing group would be able to negotiate lower prices with the pharmaceutical companies for all state residents. Administrative costs would be lower if one manager was responsible for overseeing the state's entire prescription drug purchasing programs. As an example, Medicaid Pharmacy Services, which is responsible for managing the drug program for Florida's Medicaid Program has saved nearly $500 million over the past two years with their cost-saving initiatives.[7]

Requiring pharmaceutical manufacturers to disclose marketing and advertising costs in Connecticut will give us a more realistic idea of how much those expenses are adding to the cost of prescription drugs. On a national level we already know:

- The pharmaceutical industry spent almost $16 billion on promotion of drugs in 2000 - between $8,000 and $13,000 per physician per year.
- The industry spent $2.5 billion on direct to consumer (DTC) advertising.[8]
- Increases in the sales of the 50 drugs most heavily advertised were responsible for almost half of the increase in spending in 2000.[9]

Buying drugs from Canada typically lowers prices 30 to 50 percent. Springfield, Massachusetts, which began its program to allow municipal employees to order their prescription drugs from Canada in July 2003, saved $750,000 by December of the same year.[10]

For additional information, please contact:

Gretchen Vivier
Director
Health Care for All Coalition
139 Vanderbilt Avenue
West Hartford, CT 06110
(860) 947-2200

Charlene Block
Connecticut Council of Senior Citizens
(860) 674-0143

Endnotes

"A Continuing Look at the Uninsured: Utilization of Health Care Services among Working-Age Adults (19 to 64 years)." Office of Health Care Access. 2002

[2] http://www.cga.state.ct.us/2003/pridata/Studies/PDF/Pharmacy_Findings_and_Recs.PDF

[3] "Prescription Drugs." Center on an Aging Society. September 2002. On-line available: http://ihcrp.georgetown.edu/agingsociety/rxdrugs/rxdrugs.html

.[4] "Women's Health USA 2002." U.S. Dept. of Health and Human Service. 2002.

www.statehealthfacts.kff.org

.[6] same as 3.

[7] www.fdhc.state.fl.us/Medicaid/Prescribed_Drug/index.shtml

[8] "Trends in Direct-to-Consumer Advertising of Prescription Drugs," Kaiser Family Foundation, February 2002.

[9] "Top Selling Drugs Push Drug Spending Up 17.1% in 2001," March 29, 2002.

[10] Pam Belluck, "Boldly Crossing the Line for Cheaper Drugs," New York Times, 12/11/03.

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Planned Parenthood of CT, Inc.
Quinnipiac University, Department of Nursing
Ruthe Boyea Women's Center, Central CT State University
UCONN School of Allied Health
UCONN Women's Center-Women's Health
Urban League of Greater Hartford, Inc.
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Yale University School of Medicine

Comprehensive Sexuality Education

The Connecticut Women's Health Campaign supports a woman's right to access to complete and accurate information about reproductive health care.

The Problem

Since 1996, Congress has committed over $500,000,000 in federal and state dollars for abstinence-only-until marriage programs. These programs do not include any information about contraception or disease prevention methods, with the exception of abstinence.

For the past two decades, the U.S. government has increased its investments in abstinence-only-until marriage programs. These programs present only one solution to a complex challenge. These federally funded programs deny young people lifesaving knowledge about pregnancy and disease prevention methods; inaccurate, biased, and exaggerated information as fact; and often teach specific religious beliefs.

Moreover, abstinence-only-until marriage programs consistently ignore the needs of those young people who are most at risk, including gay and lesbian youth, victims of sexual abuse, pregnant and parenting teens, and those teens who are already sexually active.

Federally funded abstinence-only-until marriage programs are prohibited from discussing the effectiveness of condoms and contraception in preventing unplanned pregnancy and disease transmission. Some curricula used in federally funded programs take this one step further by actually discouraging condom use. Teaching students that condoms or contraception do not work will not prevent them from having sexual intercourse but will likely prevent them from using these important protective measures when they do become sexually active. Recent research actually suggests that some of these programs may prove harmful to teens because those who participate are less likely to use condoms and contraception when they do become sexually active. More important, however, there is no evidence that these programs will help teens avoid or even delay sexual activity. In cases where teens make other choices later, they are armed with misinformation about birth control and condoms and are actually at greater risk for pregnancy and disease. In fact, in his report "No Easy Answer," Dr. Douglas Kirby for the National Campaign to Prevent Teen Pregnancy found that

programs that cover BOTH abstinence and contraception can delay onset of sexual intercourse, reduce its frequency, and reduce the number of sexual partners.

What Can Be Done?

Connecticut should promote and fund effective, comprehensive sexuality education. According to the National Campaign to Prevent Teen Pregnancy, the most effective curriculum-based programs:

1. Have a specific, narrow focus on behavior.
2. Are based on theoretical approaches that have been effective in influencing other risky health-related behavior.
3. Provide clear messages about sex and protection against STDs or pregnancy.
4. Provide basic, not detailed, information.
5. Address peer pressure.
6. Teach communication skills.
7. Include activities that are interactive.
8. Reflect the age, sexual experience and culture of the young people in the program.
9. Last longer than several hours.
10. Carefully select leaders and train them.

Sources:

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Characteristics of Effective Curriculum-Based Programs, "Putting What Works to Work," National Campaign to Prevent Teen Pregnancy, Number 4, September, 2003, www.teenpregnancy.org

Characteristics of Effective Sexuality and HIV Education Programs, Advocates for Youth, http://www.advocatesforyouth.org/rrr/characteristics.htm

For additional information, please contact:

Planned Parenthood of Connecticut
129 Whitney Avenue
New Haven, CT 06510
(203) 865-5158
www.ppct.org

Advocates for Youth
Suite 750
2000 M Street NW
Washington, DC 20036
(202) 419-3420 Fax: (202) 419-1448
email: questions@advocatesforyouth.org
www.advocatesforyouth.org

The National Campaign to Prevent Teen Pregnancy
1776 Massachusetts Ave., NW, Suite 200
Washington, DC 20036
(202) 478-8500 fax: (202) 478-8588
email: campaign@teenpregnancy.org
www.teenpregnancy.org

CONNECTICUT WOMEN'S HEALTH CAMPAIGN

c/o Permanent Commission on the Status of Women
18-20 Trinity Street Hartford, CT 06106
Phone: (860) 240-8300 E-mail: pcsw@po.state.ct.us
Fax: (860) 240-8314 Website: www.cga.state.ct.us/pcsw

Gender-Specific Treatment and Services for Women in Behavioral Health Care Programs

The Connecticut Women's Health Campaign supports the requirement that all state funded behavioral health programs provide gender-specific treatment and services for women. Gender-specific services are necessary to effectively meet the complex needs of women involved in the behavioral health system.

Definition of gender-specific services:
Gender-specific services are ones which intentionally allow gender identity and development to affect and guide [all aspects of] program design and service delivery.[1]

Gender-specific services and treatment for women involved in the behavioral health system can help break the cycle of relapse and recovery, reducing the costs to society that are incurred as a result of fragmented, interrupted, and repeated behavioral health treatment services that do not incorporate an understanding of females' unique treatment and service needs. Gender-specific services are particularly important for women faced with recurring mental health and substance abuse problems. Women in sustained recovery will more likely be able to maintain employment, care for themselves and their children, and be productive members of society.

The Problem

Over the past twenty years, much knowledge concerning women's services has been gained in the fields of mental health, substance abuse, and trauma treatment. For example, experts in female programming have identified the critical interplay between the trauma women have experienced, such as sexual abuse or domestic violence and their subsequent substance abuse and mental health challenges.[2] This knowledge has yet to be applied in the majority of programs serving women.[3]

Historically, programming for females involved in the mental health system has been based on research largely conducted on males (including research on the causes and correlates of substance abuse, mental health problems, and criminality) and an understanding of male development and male pathways to system-involvement.[4] The research literature on "what works" in terms of treatment tends to continue this male-oriented focus.[2,3] Programs, policies, and services often fail to identify options that are gender-responsive and culturally responsive in terms of women's needs.

Solution: Understanding Female Psychosocial Development

New literature on female development has revealed key differences in the psychosocial development of females and males.[5] Such research is furthering our understanding of the role that socialization and relationships play in women's lives and behaviors. Research has also highlighted important strengths and challenges associated with females' cultural and ethnic backgrounds.[6] For example, new theories are highlighting culturally influenced differences in female socialization processes, female responses to abuse, and female risk/protective factors for system involvement.[6] Gender-specific programming requires that providers acknowledge and adapt to women's differences and build on women's gender and cultural/ethnic strengths to enhance treatment and service effectiveness.[6]

Armed with a more accurate and comprehensive understanding of women, policy makers, administrators, managers and staff members can create effective, gender-specific programs for women that are relevant to their unique psychosocial profile.[6]

Solution: Understanding Female Risks/Strengths/Needs

By design, gender-specific services acknowledge the unique characteristics of female development **and** address those factors that research and practice indicate are particularly influential in women's lives such as trauma/victimization, domestic violence, substance abuse, mental health needs, care giving responsibilities, economic sufficiency, low or damaged self-esteem, poverty, and lack of education and vocational skills.

Along with an understanding of female psychosocial development, research on women's unique risk factors for system involvement provides additional information that must influence the form and function of program models, services and interventions for women.[4] Ultimately, research and practice indicate that such factors function as barriers to women's full engagement in services.

Solution: Implement Gender-specific Treatment and Services at All Levels

If women are to succeed in treatment and sustain recovery, behavioral health services for women must acknowledge the unique characteristics of female development, women's unique risk/strength/need profile and allow new research on women to influence all levels of service delivery. State-funded behavioral health programs must provide gender-specific treatment and services to address the unique needs of women and help ensure that women who seek behavioral health services can access relevant services that will foster success.

Gender-specific services for women actively address issues that are often barriers to treatment or sustained recovery including childcare, parenting, transportation, skills training, and housing issues. Gender-specific treatment addresses women's needs through the development of protocols to address and appropriately respond to clients who disclose sexual assault or domestic violence histories and addresses the client's sexual and domestic violence history while in treatment. Treatment plans are strengths-based and incorporate woman-defined advocacy, which focuses on women's full involvement in identifying her strengths, needs, priorities, and the identification of appropriate resources. Treatment plans are based on empowerment models, which ensure that the survivor's needs are the first priority and that services are provided to empower her recovery.

Since women exhibit specific behaviors that are unique to their gender, they require different interventions and services. Research on female development and new information regarding females' unique pathways into and within the system has led to a understanding about women's service needs and best practices in gender-specific programming for women. Such research and national best practices have provided a foundation of knowledge that is allowing researchers, practitioners, administrators, and policy makers to understand the utility of effective service delivery for women in the context of goals to reduce system involvement and facilitate long-term success.[4]

For additional information, please contact:

State of Connecticut
Department of Mental Health & Addiction Services
Valerie Leal
410 Capitol Avenue
Hartford, CT 06106
Valerie.Leal@po.state.ct.us

The Connecticut Women's Consortium
Cinda Cash
205 Whitney Avenue
New Haven, CT 06511
ccash@womensconsortium.org

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CONNECTICUT WOMEN'S HEALTH CAMPAIGN

c/o Permanent Commission on the Status of Women
18-20 Trinity Street Hartford, CT 06106
Phone: (860) 240-8300 E-mail: pcsw@po.state.ct.us
Fax: (860) 240-8314 Website: www.cga.state.ct.us/pcsw

The Connecticut Women's Health Campaign

African American Affairs Commission
CT Association for Human Services
CT Association of School Based Health Care (CASBHC)
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Removing Barriers to Gynecological Care for Women with Disabilities

The Connecticut Women's Health Campaign (CWHC) supports coverage of a wide range of health care providers and settings including community-based and culturally appropriate care.

The Problem

Women with disabilities face a number of uphill battles when trying to access women's health services. These include medical providers who are unaccustomed to treating women with disabilities, structural and communications barriers, inadequate transportation, and limitations imposed by insurance companies.

Thirty-one percent of the women with physical disabilities who participated in a national study were refused care by a physician because of their disability. A handful of Connecticut women surveyed report being discouraged or turned away from mammography and gynecological care. Others experienced pain or sustained injury during the procedure that exacerbated their disability, or incurred a financial expense in order to obtain medical services. For example, a woman who requires assistance with changing and standing for a mammogram at a facility that has a "no hold" policy, may need to pay an out-of-pocket expense for a personal care attendant to assist her. Medical facilities are less likely to offer patients added assistance for a mammogram because the reimbursement rate is the same whether it takes the allotted fifteen minutes or forty-five minutes, which is the average time a disabled woman may need. State and national research data would suggest the medical community is under-trained and facilities are not equipped to treat women with disabilities. This leads to service inequities and discrimination, which compromises the health and well being of girls and women with disabilities in our state.

What Can Be Done?

The Connecticut Women's Health Campaign (CWHC) supports the findings and implementation of the *Report on Recommendations for Gynecological Services for Women with Disabilities* written by the Department of Public Health (DPH) in collaboration with the Office of Protection and Advocacy for Persons with Disabilities (OPA). As directed by the Public Health Committee in accordance with Public Act 03-40, SB 1152, Gynecological Services for Women with Disabilities, the report was submitted to the General Assembly on January 1, 2004.

In September 2003, a workgroup was established by DPH and OPA that is comprised of state agency representatives, advocates, medical experts and consumers. It is charged with identifying and researching the barriers and obstacles women with disabilities face obtaining gynecological services; recommending ways to remove barriers in order to make services available and accessible to women with disabilities, and developing an education plan to inform the public about the recommendations and issues related to disability awareness. The Act also requires the Department of Mental Health and Addiction Services (DMHAS) and Department of Mental Retardation to ensure that preventive screenings and other women's health services are made available to women with disabilities in state-operated facilities. Among its findings, the committee identified structural barriers and attitudes as the two major obstacles preventing women with disabilities from accessing medical care.

The CWHC recognizes that implementation of the workgroup's recommendations should take place in a planned, sequential set of steps that are realistic and economically feasible. Initially, CWHC supports the workgroup's recommendations to:

- Establish a broadly representative medical advisory group to reinforce and disseminate current "best practice" standards of care reflective of American College of Obstetrics and Gynecology (ACOG), Mammography Quality Standards Act (MQSA) and the special needs of the population.
- Develop a public education campaign and materials to educate and train consumers, health care providers and the general public about disability and health related topics.
- Establish a regulatory body to monitor standards in all settings for the provision of care.
- Work with state Medicare, Medicaid and managed care organizations to increase the reimbursement rates for clients with disabilities.
- Assess private and public medical facilities to determine their level of compliance with the Americans with Disabilities Act (ADA), and soon afterwards create and distribute a complete statewide directory of medical facilities and gynecological services for women with disabilities.

Finally, CWHC recommends that the medical advisory group further examine the practice of sedation for routine gynecological procedures. Additional research is needed to determine whether the practice is widespread and to identify appropriate alternatives to curb the practice.

For additional information, please contact:

Lisa Abbey James
Women's Health Education Consultant
Connecticut Women and Disability Network, (CWDN) Inc.
60B Weston Street
Hartford, CT 06120
860 297-4375
LAJ@snet.net

Christine Fortunato
Community Advocacy Specialist and CWDN Advisory
Office of Protection and Advocacy for Persons with Disabilities (OPA)
860 297-4381
Christine.Fortunato@po.state.ct.us

Sources

U.S. Dept of Health & Human Services
National Institutes of Health and Office on Women's Health
www.nih.gov
www.4women.gov
Center for Research on Women with Disabilities (CROWD)
www.crowd@bcm.tmc.edu
2001 & 2002 CT Assessing Barriers and Creating Useful Solutions (ABACUS) Project, funded by Race for the Cure ®, the Susan G. Komen Breast Cancer Foundation
Carrie Larson, Project Coordinator
Qualidigm, Inc.
www.clarson@qualidigm.org

CONNECTICUT WOMEN'S HEALTH CAMPAIGN

c/o Permanent Commission on the Status of Women
18-20 Trinity Street Hartford, CT 06106
Phone: (860) 240-8300 E-mail: pcsw@po.state.ct.us
Fax: (860) 240-8314 Website: www.cga.state.ct.us/pcsw

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Mandatory Insurance Coverage For Wigs For Persons Who Have Lost Their Hair Due To Chemotherapy

The Women's Health Campaign supports mandatory insurance coverage for wigs for people who have lost hair due to chemotherapy. We are committed to comprehensive health care benefits which cover a full range of services that allow people to get well and to continue to live their lives as fully as possible.

The issue of insurance coverage for wigs was brought to the attention of the Connecticut Women's Health Campaign by a longtime friend of the campaign who is undergoing chemotherapy for cancer. When she lost her hair and her initial request for insurance coverage for a wig was denied, she was very angry. She advocated for herself and was able to get the initial rejection reversed. However, she wants to be sure that other people in this same position do not have to fight for this coverage as she did.

For people who lose their hair due to chemotherapy a wig is necessary to maintain their dignity and independence. A wig is a part of the essential care for patients, because they lose a part of their anatomy – in this case hair – as part of a serious medical condition. Under these circumstances, a wig is not cosmetic; it is critical for patients to maintain as much of their health as possible. Comfort and dignity in going out in public is important so that patients can:

- obtain the medical care they need;
- continue to work, if they are able;
- attend school meetings and other events for their children;
- take care of their own needs and those of their families.

This proposed legislation would mandate that insurance policies regulated by the State of Connecticut pay for the full cost of wigs for people who lose their hair due to chemotherapy or radiation treatment for cancer. It also requires that a wig would have to be prescribed by the person's oncologist.

Connecticut's law does not presently address this issue but it is addressed in other states. The Connecticut Office of Legislative Research has issued a report (2003-R-0797) stating that five states require insurers to provide coverage for wigs under certain circumstances. The states are Maryland, Massachusetts, Minnesota, New Hampshire and Oklahoma.

Sources

Connecticut Office of Legislative Research (OLR) Research Report 2003-R-0797
http://cgalites/2003/olrdata/ins/rpt/2003-R-0797.htm

For additional information, please contact:

Leslie Brett
Permanent Commission on the Status of Women
860-240-8300
leslie.brett@po.state.ct.us

Betty Gallo
Betty Gallo & Co.
860-247-4322

CONNECTICUT WOMEN'S HEALTH CAMPAIGN

c/o Permanent Commission on the Status of Women
18-20 Trinity Street Hartford, CT 06106
Phone: (860) 240-8300 E-mail: pcsw@po.state.ct.us
Fax: (860) 240-8314 Website: www.cga.state.ct.us/pcsw

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Permanent Commission on the Status of Women
Planned Parenthood of CT, Inc.
Quinnipiac University, Department of Nursing
Ruthe Boyea Women's Center, Central CT State University
UCONN School of Allied Health
UCONN Women's Center-Women's Health
Urban League of Greater Hartford, Inc.
Valley Women's Health Access Program, Griffin Hospital
Yale University School of Medicine

Microbicides: Woman-controlled Protection from HIV and other STDs

The Problem

AIDS is the biggest epidemic in history with 15,000 new HIV infections occurring worldwide every day. HIV is turning into a woman's epidemic: worldwide, six in ten newly infected people are women. Likewise, Connecticut's HIV epidemic has become a women's issue. To address women's disproportionate risk we must work to empower women and promote non-violent, egalitarian family relationships. But we can also give women the tools to protect themselves, including female condoms and topical microbicides.

The Connecticut Women's Health Campaign supports the development of microbicides as a promising element of the reproductive health care of the future. Still in the early stages of clinical trials, microbicides could be produced in many forms: gels, creams, suppositories, sponges, vaginal rings or vaginal wipes. When applied to the vagina or rectum, they would substantially reduce transmission of sexually transmitted diseases. Because these products may or may not contain contraceptive qualities, pregnancy may be able to occur even when they are in use.

What Can Be Done?

Development of microbicidal agents will require significant federal investment. Large pharmaceutical companies have had relatively little interest in pursuing this research due to perceived low profitability of the product, liability concerns, lack of in-house expertise or the uncertainty of the regulatory environment. For this reason, for the last 20 years almost all funding for contraceptive development and related research has come from governments and private foundations. We are asking members of the Connecticut Congressional delegation to sign onto the Microbicides Development Act that would secure federal funds for the National Institutes of Health to conduct this research. Senator Christopher Dodd has been an early co-sponsor of this legislation.

It is estimated that 21.3 million women in the US alone would be interested in using a microbicide. Even in resource-poor countries, women at risk are willing to pay twice as much as the local price of a condom to obtain a microbicide. In an acceptability study conducted recently by the Hartford-based Institute for Community Research, women at high risk, including sex workers, were asked whether they would use a microbicide for HIV prevention with primary, casual or paying partners, and virtually 100 % were willing to do so.

For additional information, please contact

Members of "Microbicides NOW, Connecticut":
Susan Yolen or Shanta Evans
Planned Parenthood of Connecticut
203-865-5158

Laurie Sylla
CT AIDS Education Training Center
Yale University School of Nursing
Church Street South
New Haven, CT 06519
203-737-2361

Source:

Global Campaign for Microbicides
www.global-campaign.org

CONNECTICUT WOMEN'S HEALTH CAMPAIGN

c/o Permanent Commission on the Status of Women
18-20 Trinity Street Hartford, CT 06106
Phone: (860) 240-8300 E-mail: pcsw@po.state.ct.us
Fax: (860) 240-8314 Website: www.cga.state.ct.us/pcsw

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Ruthe Boyea Women's Center, Central CT State University
UCONN School of Allied Health
UCONN Women's Center-Women's Health
Urban League of Greater Hartford, Inc.
Valley Women's Health Access Program, Griffin Hospital
Yale University School of Medicine

Gender Competent Treatment and Services for Women Experiencing Gambling Problems

The Connecticut Women's Health Campaign supports the requirement that all state-funded behavioral health programs provide gender competent treatment and services which are necessary to meet the complex needs of women with behavioral health problems.

The Problem

While it is generally accepted that women in substance abuse recovery have complex and differing needs from their male counterparts, the case for gender competent treatment for women seeking help for their gambling problems has yet to be made in Connecticut. Indeed, treatment of female pathological gamblers is a relatively recent phenomenon.

- Connecticut is home to the oldest state-funded gambling treatment program, established in Bridgeport in 1982. Problem gambling describes any gambling behavior that chronically results in negative consequences. Commonly called compulsive or addictive gambling, pathological gambling is the most severe form of problem gambling. Recognized by the American Psychiatric Association as a distinct mental disorder since 1980, pathological gambling is defined as a chronic and progressive failure to resist impulses to gamble despite mounting negative consequences. Lying to hide gambling, over spending, neglecting responsibilities and important relationships, losing employment and engaging in criminal behavior are among the typical consequences.

- With increases of variety and opportunity to gamble has come growth in the numbers of people experiencing gambling related problems. Women are currently the fastest growing group seeking treatment for problem gambling in Connecticut.[i] Prior to the early 1990's, pathological gamblers seeking treatment were almost exclusively male.[ii] Currently, about 40% of gamblers seeking treatment are women.[iii] Additionally, most women who seek help for a gambling problem are between the ages of 40-60,[iv] suggesting that societal roles (transitions in child rearing and work responsibilities) and biology (menopause and aging) may play a part in the development of their gambling problems.

- Compared to male gamblers who seek treatment, women gamblers tend to be older and have briefer gambling histories prior to seeking help.[v] Childhood

maltreatment is prevalent in pathological gamblers, and women experience more severe abuse and neglect than men.[vi] Additionally, the rates of lifetime abuse or neglect are slightly higher among treatment-seeking gamblers than among treatment-seeking substance abusers.[vii]

- Women gamblers are more likely than men to be living with a problem gambler or problem drinker (but women themselves have fewer alcohol and legal problems).[viii] Twenty-five percent of women problem gamblers have dependent children at home, and 40% of women problem gamblers earn less than $40,000.[ix]

- Problem gambling often occurs with other difficulties: the rate of problem and pathological gambling for those in mental health and substance abuse treatment settings is four-to-ten times higher than the general population.[x] Other problems associated with gambling as reported by problem gamblers seeking treatment include: depression and anxiety, suicidal ideation, family or spouse conflict, family neglect, use of equity or savings, difficulty paying household bills, past or pending bankruptcy, and illegal acts. [xi]

What Can Be Done?

- Screen for gambling problems: Considering the co-morbidity of problem gambling with mental health issues and substance abuse, and the prominence of past abuse and neglect, it is critical for health providers in these fields to screen for gambling on intake.

- Train for service providers in assessment and referral: Training will ensure the implementation of problem gambling assessment, and facilitate appropriate referral. Additionally, it will support the integration of problem gambling treatment protocols within existing systems of care already utilized by the problem gamblers.

- Conduct research: To understand gender differences may assist in developing treatments that address differential needs of male and female pathological gamblers, and in preventing those at-risk from developing gambling problems. More research is needed to determine the most effective treatments for women.

For additional information, please contact:

DMHAS Problem Gambling Services
CVH, Box 351, Russell Hall
Middletown, CT 06457
860-344-2244
www.gamblingrecovery.org

CT Problem Gambling Helpline
24-hour, toll-free, confidential
1-800-346-6238

CT Women's Consortium
205 Whitney Avenue
New Haven, CT 06511
203-498-4184
www.womensconsortium.org

CT Council on Problem Gambling
47 Clapboard Hill Road
Guilford, CT 06437
203-453-0138
www.ccpg.org

Endnotes

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c/o Permanent Commission on the Status of Women
18-20 Trinity Street Hartford, CT 06106
Phone: (860) 240-8300 E-mail: pcsw@po.state.ct.us
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Planned Parenthood of CT, Inc.
Quinnipiac University, Department of Nursing
Ruthe Boyea Women's Center, Central CT State University
UCONN School of Allied Health
UCONN Women's Center-Women's Health
Urban League of Greater Hartford, Inc.
Valley Women's Health Access Program, Griffin Hospital
Yale University School of Medicine

Connecticut's Women's Health: A Blueprint For The Future

PREVENTION & GENDER COMPETENT SERVICES

I. Environmental Cause And Mapping Of Breast Cancer

Legislative Proposal To appropriate funding to the state Department of Public Health for the purpose of mapping incidence of breast cancer to determine whether there are any "clusters" in CT that might indicate environmental causes of the disease.

Background: Scientists define "cancer clusters" as places where cancer rates are unusually high or low for reasons other than chance.[1] Breast cancer rates vary by geographical region, suggesting the environment may hold clues to its causes. Most breast cancer research has focused on detection and treatment, with little funding or attention paid to identifying preventable causes. Since research has determined that increased exposure to estrogen over a woman's lifetime increases her risk of breast cancer, scientists are asking whether exposure to chemicals that mimic estrogen might also be linked to breast cancer. Estrogen mimicking chemicals are found in common products like pesticides, detergents and plastics.[2]

A study published in the *New England Journal of Medicine* found that only approximately 27% of breast cancer risk is attributable to genetic factors. This means that other factors, which may be preventable, are the predominant cause of breast cancer. The article defined "environmental factors" broadly to include pollutants and workplace exposures along with diet, smoking, and other factors.[3]

II. Osteoporosis Early Detection And Treatment Referral Program

Legislative Proposal To require the state Department of Public Health to establish an osteoporosis prevention, early detection and treatment referral program to promote prevention, screening detection and treatment of osteoporosis among unserved or underserved populations, to educate the public regarding osteoporosis and the benefits of prevention and early detection and to provide counseling and referral services for treatment. "Unserved or underserved populations" means women who are: (i) at or below 200% of the federal poverty

level for individuals; (ii) without health insurance that covers osteoporosis screening; and (iii) 19 to 64 years of age.

Background:[4] Osteoporosis is a serious, degenerative bone condition affecting the health of approximately 23 million American women. More than 8 million women have the disease, while over 14 million have osteopenia or "low bone mass" placing them at increased risk of developing osteoporosis. Eighty percent of people with osteoporosis are women. Females experience hip fractures at a rate two to three times higher than males. One in five persons dies within a year of sustaining an osteoporotic hip fracture. A woman's lifetime risk for an osteoporosis-related hip fracture is equal to her risk of breast, uterine and ovarian cancer combined. Between 1993 and 1997, there were 2,827 females discharged from Connecticut acute care hospitals with a primary diagnosis of osteoporosis and 17,046 female discharges that were osteoporosis-related. By 2015, the number of Connecticut females with both osteoporosis and low bone mass is expected to increase by 36 percent, from 316,613 to 429,000.[5]

The anticipated number of individuals with osteoporosis may also be on the rise due to asthma related treatment. About 18 million Americans have asthma and 5 million of them are children.[6] In 2000, it was estimated that 119,116 Connecticut adults had asthma.[7] Asthma sufferers may take "long-term-control" medications, e.g. corticosteroids, to relieve their symptoms. Although low and medium dosages of inhaled corticosteroids appear to have no major adverse effects on any clinically important measure of bone metabolism, a dose-dependent, yet significant, reduction in bone mineral contents of subjects with asthma has been associated with inhaled corticosteroid use.[8]

Osteoporosis is accurately named the "silent disease" because it weakens and thins bones without early warning signs or symptoms. The development of maximum bone strength and density begins in early childhood, and the skeletal bones reach their peak density by about age 30. A woman's risk for osteoporosis increases with the number of her risk factors. Although some of the risk factors are non-modifiable, e.g. being female or early menopause, many are modifiable, e.g. current cigarette smoking, low lifelong calcium intake, low vitamin D intake, low body weight, anorexia, lack of weight-bearing exercise, and long-time use of certain medications. Osteoporosis is highly preventable and treatable, but as of now there is no cure. Prevention efforts are targeted toward two processes in a woman's life: the development of a greater peak bone mass early in life and slowing the rate of bone loss after menopause. Bone mineral density screening exams are relatively quick, painless, and noninvasive tests that can detect, predict, and monitor a person's risk for an osteoporosis fracture.

III. Nutritional Counseling And Therapy

Legislative Proposal To require insurers to provide coverage for medically necessary Medical Nutrition Therapy authorized by a physician for conditions including, but not limited to: hypertension, hypercholesterolemia, hypertriglyceridemia, obesity, morbid obesity, eating disorders, inflammatory bowel disease, gastro-esophageal reflux disease, chronic renal insufficiency, cancer, HIV, unexplained weight loss, malnutrition, malabsorption, prenatal nutrition care, enteral nutrition support and parenteral nutrition support. The patient's physician would authorize the number of visits covered.

Background: Medical Nutrition Therapy (MNT) can be used to treat a wide variety of diseases and conditions and can help reduce the overall cost of health care. Coverage is inconsistent among insurance plans, which results in deferred care, which in turn ultimately increases the cost of health care and increases morbidity and mortality in Connecticut residents. Several medical conditions, which disproportionately affect girls and women such as eating disorders, osteoporosis and pregnancy, are among those for which medical nutrition therapy would be particularly beneficial.

IV. School Nutrition

Legislative Proposal To require the state Department of Education to (A) Require all schools to adhere to state regulations regarding the sale of "extra foods" in vending machines, and; (B) create stronger enforcement mechanisms for existing regulations that require schools to shut off vending machines during certain school hours.

Background: The rate of obesity has risen in the nation and has resulted in increases to preventable conditions such as diabetes, cancer, and cardiovascular disease. Over the past decade, schools have made significant strides in improving the nutritional content of meals served in school cafeterias. But those meals are supplemented by an array of alternative sources, such as vending machines, which frequently offer fatty and salty foods that are not as healthy as cafeteria meals. Vending machines are a major impediment to maintaining good eating habits at school.[9]

Per state board of education regulations, if students have access to vending machines containing "extra foods," the machines must be turned off 30 minutes before and 30 minutes after any state or federally subsidized milk or service program. "Extra foods" are defined as tea, coffee, soft drinks and candy.[10] Only those schools participating in state or federally subsidized food programs must abide the regulation. There are a few districts in the state that do not need to close down their vending machines.

V. Behavioral Health

Legislative Proposal: To require all state funded behavioral health programs to provide gender competent treatment and services.

Background: Gender competent treatment and services are necessary to meet the complex needs of women with behavioral health problems. Women and men have different treatment needs. For women, behavioral health treatment is complicated by the intersecting roles and responsibilities of motherhood and women are more likely to suffer from increased levels of shame, guilt, interpersonal problems, financial difficulty stigmatization, lack of marketable job skills, and social support. In women, mental health problems and histories of sexual or physical abuse frequently co-occur with substance abuse disorders. Violence against women is closely associated with depression and anxiety disorders. Fifty to ninety-five percent of women who have been raped will develop PTSD.[11] Up to 70% of women in drug abuse treatment report a history of physical and sexual abuse with victimization beginning before 11 years of age and occurring repeatedly.[12] In addition, women who were sexually abused are significantly more likely to report one or more symptoms of eating disorders than their non-abused peers. [13] At least 30% of female trauma patients have been victims of domestic violence.[14] Women in recovery from substance abuse are likely to have a history of trauma and are high risk of being diagnosed with posttraumatic stress disorder.[15] A 1995 Johns Hopkins University School of Medicine survey of nearly 2,000 female patients found that one in three women had experienced domestic violence as an adult or child.[16]

For women to succeed in treatment and sustain recovery, behavioral health treatment must address the impact of violence in women's lives and the particular needs of women in treatment. Gender competent services for women address issues that may be barriers to treatment or sustained recovery including childcare, transportation, skills training, and housing. Gender competent treatment addresses women's needs through the development of protocols to address and appropriately respond to clients who disclose sexual assault or domestic violence histories and addresses the client's sexual and domestic violence history while in treatment. Treatment plans also incorporate woman-defined advocacy and empowerment models, which address women's experience, strength, and needs.

Women in sustained recovery will be able to maintain employment, care for themselves and their children and be productive members of society. One study shows that one year after treatment 40% of women eliminated or reduced their dependence on welfare.[17] Greater collaboration and coordination between agencies and providers will create pathways for comprehensive services and violence prevention and enhance women's abilities to sustain their recoveries and treatment, and thereby reduce the costs to society that are incurred as a result of fragmented, interrupted, and repeated behavioral health treatment services.

VI. Improving The Response To Sexual Assault Victims

Legislative Proposal: To increase funding for rape crisis centers in the Department of Public Health Budget by $250,000 to fund five regional Sexual Assault Response Team Coordinators to establish Sexual Assault Response Teams throughout the State.

Background: A sexual assault response team (SART) is an interagency sexual assault response model based on a team approach. A SART typically includes representatives from a local sexual assault crisis service, the hospital emergency department, the prosecutor's office, and law enforcement agencies. SARTs facilitate a victim-focused, multidisciplinary, coordinated response to sexual assault. This approach prevents secondary victimization[18], which exacerbates the negative physical and psychological health effects of sexual assault. A SART may result in increased reporting and prosecution of sexual assault crimes within the community served by the team.

ACCESS TO HEALTH CARE

VII. Health Insurance Expansion

Legislative Proposal: Maintain and expand health insurance coverage by: (A) Requiring the state Department of Social Services to apply for a federal waiver to provide insurance coverage for all parents up to 300% of the federal poverty level; (B) Requiring the state Department of Social Services to apply for a federal waiver to provide insurance coverage up to 300% of the federal poverty level for pregnant women for up to two years after a pregnancy; (C) Requiring the state Department of Social Services to apply for a federal waiver to provide insurance coverage for family planning, including STD diagnosis and treatment, for adults up to 300% of the federal poverty level; and (D) Requiring the state Comptroller to allow small business employers to obtain insurance coverage through the Municipal Employees Health Insurance Plan (MEHIP).

Background: There are approximately 253,000 uninsured persons in the state of Connecticut; the rate of uninsured adults is approximately 8.5%. Among those who are uninsured, 11.3% have incomes below 100% of the Federal Poverty Level (FPL); 32% have incomes between 100% and 199% of FPL; 13% have incomes between 200% and 299% of FPL; and a surprising 43.4% have incomes over 300% of the federal poverty level. As many as 70% of those who lack health insurance are working and approximately 15% more are dependent children or spouses of workers; only 15% of the uninsured have no formal attachment to the labor force.[19] Because of this distribution of uninsured adults and dependents, Connecticut needs a multi-pronged strategy to provide access to health care coverage.

The proposals above would allow Connecticut to expand health insurance coverage to various target populations by utilizing Medicaid funds at a 50% federal reimbursement rate; SCHIP funds at a 65%-90% federal reimbursement rate; and the MEHIP Plan which is not a government subsidized program, but uses the purchasing power of the state to secure affordable health insurance.

For example, since the mid 1990s, states have used Section 1115(a) Medicaid Demonstration waivers to cover family planning services for certain populations. They are attractive because the federal government pays 90% of the costs for services, while the state pays 10%. Most family planning waivers are good for a five-year period. Twelve states are currently operating statewide family planning waivers [Arizona, Arkansas, California, Delaware, Florida, Maryland, Missouri, New Mexico, New York, Oregon, Rhode Island, and South Carolina]. Six more states are in the process of applying for a family planning waiver and five additional states are considering it.

VIII. Gynecological Services For Women With Disabilities

Legislative Proposal: To provide women with disabilities equal access to gynecological services by: (A) Requiring hospitals to develop and submit procedures to the state Department of Public Health regarding their gynecological services for women with disabilities that includes a description of services and accommodations available, and procedures governing confidentiality and consent; (B) Requiring the Department of Mental Retardation (DMR) to develop policies and procedures regarding the use of sedation for gynecological procedures that inform and safeguard DMR female clients. (C) Requiring hospitals and the Department of Mental Retardation (DMR) to establish a medical review process before someone is sedated for routine exams to determine whether (i) there is absolutely no other alternative to sedation; and (ii) the benefit of the exam outweighs the effects of the sedation and / or procedures; and (iii) the patient has provided informed consent; (D) Requiring hospitals to submit a report, on an annual basis, of its policy regarding the provision of hearing and speech interpretive services; (E) Requiring the state Department of Mental Health and Addiction Services (DMHAS) to expand its requirement for yearly physicals to include mammography and pelvic examinations, and; (F) Providing funding for an education and awareness project for consumers and medical professionals, including but not limited to: (i) educating consumers about medical procedures to ensure that consumers have an opportunity to consent to sedation prior to the actual exam; and (ii) educating medical professionals about less invasive alternative procedures and sensitivity to the needs of women with disabilities.

Background: It is common practice for medical professionals to sedate individuals with disabilities when providing routine medical services such as mammograms, dental and pelvic exams. The individual does not always have the opportunity to consent to sedation. Although this is an issue that affects all individuals with disabilities, women are disproportionately affected because they generally undergo several routine gynecological examinations. This practice is often perpetuated for convenience rather than medical necessity, does not provide equal protection to individuals with disabilities, and is often experienced by consumers as physical and mental. Additionally, women with disabilities are not provided gender competent services. For example, the state Department of Mental Health and Addiction Services' policy is to require a yearly physical for its clients. However, the yearly physical does not include procedures that are routine for women, e.g. mammograms and pelvic examinations.

IX. Prescription Drug Coverage

Legislative Proposal: To ensure that consumers have access to reasonably priced prescription drugs by: (A) Establishing a state purchasing system which creates discounted prices for prescription drugs, and (B) Establishing a review board to monitor prescription drug prices.

Background: More than 700,000 state residents are without prescription drug coverage,[20] while the cost of prescriptions is increasing nationwide at a rate of over 17%.[21] Many state programs are being cut due to lack of adequate revenue.

"Women are generally more likely than men to use prescription drugs. Some 40 percent of men and 66 percent of women age 18 to 34 use prescription drugs. Use patterns converge as people get older. Similar proportions of men and women age 65 and older are prescription drug users."[1] One must remember, though, that 58% of the over 65 population are females.[2]

Older women are significantly impacted by the rise in prescription drug costs. According to the U.S. Food and Drug Administration, older women take an average of seven different medications at any given time. The majority of older women rely on Medicare coverage that does not cover prescription medications. This lack of prescription coverage translates into a hefty individual bill. According to the Kaiser Foundation the average price per prescription in Connecticut is $52.93.[3] For older, uninsured women taking an average of seven different medications, this translates into $371 a month for out-of-pocket prescription drug expenses.

X. Patients' Right To Know

Legislative Proposal: To protect all patients' right to know about medical options and to make informed decisions regarding their health and medical care by amending regulations to ensure that no hospital, health care clinic, health care provider, health maintenance organization, insurer, or other entity shall, by contract, by law or other means prohibit a physician or other health professional from discussing or recommending any medical treatment or medication that is medically accepted and a reasonable option for a patient's condition or ongoing treatment, regardless of whether the treatment or medication is available at the location at which the patient is treated.

Background: Consumers have the right to receive complete and scientifically accurate information about all medical services and options, including those that are controversial, contrary to some religious beliefs, expensive, or not covered by their insurance. This protection is particularly important to protect consumers' right to know about family planning services, including emergency contraception and abortion.

XI. Midwifery Care

Legislative Proposal: To protect consumer access to professional, out-of-hospital maternity care services and increase the range of quality maternity care choices available to consumers.

Background: While maternity care in the United States has evolved into a $50 billion per year industry, rates of infant mortality, premature birth, low birth weight, induced labor, vacuum extraction, and cesarean section have risen or remained unacceptably high. One response has been for consumers to seek alternatives to standard maternity care practices, including planned, out-of-hospital birth attended by trained midwives. Out-of-hospital birth attended by skilled midwives has been proven to be a safe and cost-effective option for healthy, low-risk mothers. Clinical research has shown midwifery care to be associated with lower rates of cesarean section, lower rates of forceps and vacuum extraction, lower rates of admission to neonatal intensive care units, lower rates of postpartum hemorrhage, higher birth weights, higher Apgar scores, higher rates of breastfeeding, fewer infant deaths, fewer maternal deaths, higher rates of vaginal birth after cesarean, reduced maternity care costs, and greater satisfaction with the birth experience among mothers.

Nationally, approximately 2,000 practicing midwives entered the profession directly through midwifery education and training, rather than through a pre-requisite program such as nursing. This led to the establishment, in the 1990s, of two national certification designations for direct-entry midwives: the Certified Professional Midwife (CPM) and the Certified Midwife (CM). Both the CPM and CM credentials require didactic programs, written examinations, and clinical experience. However, the CPM and CM are distinct credentials conferred by different accrediting bodies and emphasizing different skills.

The full integration of direct-entry midwives into the health care system in Connecticut increases the range of quality maternity care choices available to consumers, increases access to midwives, and introduces the likelihood of improving outcomes for mothers and infants while simultaneously reducing overall maternity care costs.

SUPPORTING COMMUNITY HEALTH

XII. Restore Health Services

Legislative Proposal (A) To restore Medicaid, State Administered Medical Assistance (SAGA), and town General Assistance (GA) medical coverage to include (i) eye care, optical hardware, optometry care, home health care, and (ii) services by psychologists, naturopaths, chiropractors, physical, occupational and speech therapists and podiatrists, and (B) To restore SAGA medical transportation.

Background: Per the State budget, Medicaid and State Assistance optional service cuts include services by psychologists, naturopaths, chiropractors, physical, occupational and speech therapists and podiatrists. In addition, home health care and vision, including optical hardware, services have been cut for SAGA.

XIII. Expand Community Services

Legislative Proposal: To expand services at community health centers and school based health clinics to adequately serve the uninsured.

Background: School Based Health Centers, as defined by the Connecticut Department of Public Health, offer comprehensive medical, mental health, and in some cases dental care to the children enrolled in a particular school that has received funding for this purpose. Currently in Connecticut there are 68 schools in 18 communities with School Based health centers. Included in this number are 22 high schools and 15 middle schools. With 17 years of experience in Connecticut, school based health centers have proven their ability to provide quality health care that is unique because of its accessibility to students. Both preventive and minor acute care services are regularly available.

School based health centers must now bill to third party payors for reimbursable visits and expenses. Though many children receive their primary care services at the school based health center, private insurers have the option of contracting (or not) with them. Parents are not charged co-pays or any out-of-pocket fees. With flat funding from the State of Connecticut, and the inability to bill for reimbursable services, centers are faced with tough choices about staffing and services offered.

Adolescent women are very active consumers of school-based services for their reproductive health care. Pregnancy prevention efforts are vigorous, realizing the high cost of a teen pregnancy both to the teen and to the community at large. Providers have received specialized training in the diagnosis and treatment of sexually transmitted diseases. By state statute, adolescents have the right to confidential reproductive health care (although they must have a general parental permission to use the health center). For many students, the school based health center is their only option for getting this confidential care because of the difficulty getting transportation to another facility or having to pay out of pocket for their visit. Both of these barriers are eliminated with SBHC.

Community Health Centers are mandated to go far beyond the provision of traditional medical services. They ensure that people receive comprehensive support services such as: dental care, child care, career counseling, literacy training, referrals to substance abuse providers, transportation, patient education, Healthy Start case management, early education supports, translation services, housing assistance, social service eligibility assistance, mental health, and assistance with HUSKY enrollment. Federally qualified health centers (FQHCs) in Connecticut are losing $1 million annually because of the way the state Department of Social Services (DSS) have calculated their prospective payment rate using 4,200 visit screen per physician FTE which the Federal Courts have found unlawful. As a result of losses from DSS rate setting and cuts to the state Department of Public Health funding to care for the uninsured, health centers will be forced to close service delivery sites, restrict hours, reduce staff, and eventually close their doors altogether. This will leave entire communities without any access to priority and preventive health care services. Over 75% of health center

patients have their care paid by Medicaid, Medicare, and other federal grants to care for the uninsured. Health centers cannot compensate for inadequate state resources to the uninsured through Medicaid dollars.[25]

XIV. Smoking Prevention And Cessation

Legislative Proposal To appropriate funding to the state Department of Social Services, for the fiscal year ending June 30, 2004, for the purpose of implementing the Department of Social Services' Medicaid state plan to provide smoking cessation services.

Background: Currently, smoking cessation programs and aids are not covered under Medicaid, and many low-income people cannot afford them. According to the U.S. Department of Health and Human Services, Agency for Health Care Policy and Research, the average cost per smoker for successful smoking cessation interventions is $165.61. On the other hand, the cost of treatment for smoking related illnesses such as cancer or heart disease can be thousands of dollars. The health costs directly related to tobacco use are exorbitant. In Connecticut, it is estimated that annual "tobacco-caused" health care expenditures total $1.2 million dollars a year, which averages $476 dollars per year per average household.[26] The state and federal tax burden associated with these costs total $589 million a year.

In 2002, the General Assembly passed *PA 02-4, An Act Concerning the Provision of Smoking Cessation Services Under the State Medicaid Plan and Making Technical Corrections to Special Act 01-11 of the November 15 Special Session*, which requires the Commissioner of the state Department of Social Services to amend the Medicaid state plan to provide coverage for treatment for smoking cessation when such treatment is ordered by a licensed health care professional. The Commissioner presented a plan to the Human Services and Appropriations Committees in 2003.

XV. Community Support Services For Elders And People With Disabilities

Legislative Proposal: To provide community support services for elders and people with disabilities by: (A) Maintaining open enrollment to the Connecticut Home Care Program for Elders for all eligible clients; (B) Amending the income eligibility for Levels One and Two of the Connecticut Home Care Program for elders to match the ConnPACE Program of $20,000 per individual and $27,000 per couple; (C) Increasing the care plan limits for formal services by raising the current formulary in each category to more closely approximate the costs of nursing home care. Any additional costs to the program would be offset by the delay and prevention of nursing home placement; (D) Opposing efforts to change the rules concerning the transfer of assets for Medicaid eligibility; (E) Requiring the state Department of Social Services to provide personal care assistance services under the Independence Plus Waiver to the same extent and beyond that such services are provided in the personal care assistance waiver pursuant to section 17b-262-58 of the Connecticut General Statutes; (F) Appropriating the sum of $500,000 annually to the state Department of Social Services for the purpose of funding the Center for Medicare Advocacy; (G) Appropriating the sum of $100,000 annually to the state Department of Social Services for the purpose of funding the CHOICES Program to improve consumer access to information and services that provide a range of community resource topics including Medicare, Medicaid and Medigap, and; (H) Requiring the state Department of Social Services to establish and administer a transition assistance program, which shall provide transition services to individuals who reside in a long term care facility, are Medicaid eligible and many appropriately return to the community. Transition services shall include but not be limited to care management, personal care services, security deposits, furnishings, and any other services.

Background: In Connecticut as well as nationwide there is a growing population of elders who will increasingly rely on services that help them remain independent and in their communities. The fastest growing cohorts of this population are individuals 85 plus and female. The 2000 Census shows that 46,341 women age 85 and over resided in Connecticut. This number is projected to increase by nearly a third in the year 2010 to 72,515.

The number of people with disabilities also continues to grow and with this growth is a burgeoning movement by those with physical and psychiatric disabilities to remain independent through self-directed care. According to the latest US census 19% of all people have disabilities. People with disabilities are often dually eligible for Medicare and Medicaid.

The U. S. Supreme Court ruling in Olmstead v. L. C., 119 S. Ct. 2176 (1999) mandates that services be available to meet the needs of such persons wishing to live in the community. Older women and non-elders with disabilities wish to remain in a community setting. Not only because the cost effectiveness of this choice is clear, but it is the "right thing to do." Older women and non-elders with disabilities are able to remain in a community setting because of the following community support services:

- The Connecticut Home Care Program for Elders - a responsive system of care management and provision of necessary services, which currently has 12,000 active participants.
- The Center for Medicare Advocacy - provides excellent education and advocacy to Medicare beneficiaries throughout the state of Connecticut.
- The Connecticut's Program for Health Insurance Assistance, Outreach, Information and Assistance, Counseling and Eligibility Screening Program (CHOICES) - provides valuable information to older adults via an information and referral program operated by the Area Agencies on Aging.
- Additionally, Connecticut currently has five home and community based waivers that serve a limited number of people with specific disabilities of particular age groups.

EDUCATION & AWARENESS

XVI. Biennial Report On The Health Status Of Women

Legislative Proposal To provide data analysis and education about the health status of women by: (A) Funding the Permanent Commission on the Status of Women (PCSW) to prepare a biennial report; and (B) Preparing a biennial report to provide information regarding breast and ovarian cancer, domestic violence, sexual assault, and the link between smoking, weight loss and obesity, HIV/AIDS, depression, adolescent health, emergency contraception, and access to services by women with disabilities.

Background[27]: During the last century, factors such as improvements in medical technology, environmental controls, social legislation and personal lifestyle changes have increased a woman's life expectancy dramatically – from 48 years for a woman born in 1900 to 80 years for a woman born in 1998. Because the reproductive years now constitute less than half of a woman's life expectancy, the definition of women's health has broadened beyond reproductive health to consider social issues, chronic conditions, infectious diseases, and injury and violence that affect women throughout their lives. It is essential to begin to track the conditions that are unique to or more prevalent in females, and report this information to state residents.

Endnotes

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CONNECTICUT WOMEN'S HEALTH CAMPAIGN

c/o Permanent Commission on the Status of Women
18-20 Trinity Street Hartford, CT 06106
Phone: (860) 240-8300 E-mail: pcsw@po.state.ct.us
Fax: (860) 240-8314 Website: www.cga.state.ct.us/pcsw

The Connecticut Women's Health Campaign

African American Affairs Commission
CT Association for Human Services
CT Association of School Based Health Care (CASBHC)
CT Breast Cancer Coalition, Inc.
CT Citizen Action Group
CT Coalition Against Domestic Violence
CT Coalition for Choice
CT Community Care, Inc.
CT Legal Rights Project
CT NOW
CT Primary Care Association
CT Sexual Assault Crisis Services
CT Voices for Children
CT Women and Disability Network, Inc.
CT Women's Consortium, Inc.
Disability Services, City of New Haven
Hartford College for Women
Institute for Community Research
Latino and Puerto Rican Affairs Commission
Mental Health Association of CT, Inc.
NARAL Pro-Choice ConnecticutNational Association of Social Workers, CT Chapter
National Council of Jewish Women
National Ovarian Cancer Coalition
CTOlder Women's League of NWCT
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Connecticut Women's Health Campaign Statement of Principles

UNIVERSAL COVERAGE which is affordable and accessible for all people regardless of income, age employment status, immigration status or location of residence. This is especially important to women who comprise the largest group of poor people in the country and have the highest proportion of part-time workers, and especially for women of color who face additional barriers because of racism. To make the promise of universal coverage real for all women, the new health care plan must include a cap on premiums and co-pays based on a percent of income model.

COMPREHENSIVE BENEFITS PACKAGE which covers a full range of services including but not limited to reproductive health care (including contraception, prenatal care and abortion), mental health and substance abuse treatment, preventive health care (including early detection services such as mammography, PAP smears, pelvic exams, and testing for HIV and STD's), acute and long-term care, and rehabilitative care.

INCLUSION OF A WIDE RANGE OF HEALTH CARE PROVIDERS AND SETTINGS. Providers should include mid-level practitioners such as midwives and nurse practitioners, and settings should include neighborhood health centers, family planning clinics and other programs that provide effective culturally and linguistically appropriate health care.

INCREASE ATTENTION TO WOMEN'S HEALTH NEEDS IN THE NATIONAL RESEARCH AGENDA, especially for the prevention and treatment of breast cancer and other medical conditions which disproportionately affect women, and the guaranteed inclusion of women in clinical trials and research samples for all medical conditions that affect women. Also, states should be required to collect data about women's health.

EQUAL REPRESENTATION OF WOMEN AT ALL LEVELS OF DECISION-MAKING, RESEARCH AND SERVICES DELIVERY, including those of different races, ages, income levels and sexual orientation. In addition, health care consumers should be included in the decision-making process.

CONFIDENTIALITY WHICH IS ESSENTIAL TO PROTECT ACCESS for all people including, but not limited to minors, people with HIV infection, people seeking reproductive health care, and survivors